



From "THE PRACTITIONER" for September, 1897.

A PLEA FOR THE EARLIER PERFORMANCE OF GASTROSTOMY.

BY A. W. MAYO ROBSON, F.R.C.S.,

*Senior Surgeon to the General Infirmary at Leeds; Professor of Surgery in
the Yorkshire College of the Victoria University.*

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THE operation of gastrostomy is ordinarily looked on as such a formidable procedure that, even where it is strongly indicated, the general medical attendant usually views it with so much disfavour as to lead him to discountenance its performance and to trust to sustaining existence in irremediable dysphagia by nutrient enemata.

Death by starvation under such circumstances is, however, one of the most terrible experiences both to the patient and his friends, and the reason of this paper is to raise the question whether the views originally held are not erroneous, and whether surgery does not hold out much better prospects to this unfortunate class of cases.

Why has the operation of gastrostomy acquired this ill-repute?

In the first place, because it was, and even yet as a rule is, customary to defer it until the sufferer is so reduced by starvation and so enfeebled as to be unable to withstand the shock of any operative procedure. Even if he does not die of shock, his healing powers are so impaired as to lead to failure in union and then to death from wound complications; or his assimilative powers are so impoverished that, even if the operation be immediately successful, death ensues from exhaustion.

In the second place, when a direct opening is made into the stomach the fistula, in many cases, speedily enlarges and becomes patulous, leading to leakage of food and of irritating gastric secretion, so that the abdomen tends to become excoriated and the prolongation of life is attended with considerable discomfort. Do these conditions still apply? I think I shall be able to show that if the operation be performed sufficiently early, and if it be done according to the method I am about to describe, it will be found that gastrostomy may be included among the most useful and beneficent of the operations the surgeon is called upon to perform. When abdominal section was attended with a high rate of mortality, it was only natural that, if there was the smallest element of doubt as to the nature of the disease causing the dysphagia, delay should occur in advising operation; but if it can be shown that early operation has no mortality or only a slight rate due to accidental or unforeseen complications, it may be justifiable to perform the preliminary or even the complete operation, knowing that the small opening will close voluntarily if the cause of the dysphagia should disappear or be cured by treatment.

The operation I am accustomed to perform is very simple, and only occupies a few minutes; it is a modification of the Ssabanejew-Franks method, but differs in several details.

A vertical incision of about an inch and a half is made over the outer third of the left rectus abdominis, commencing three quarters of an inch below the costal margin; the fibres of the rectus are separated, but not divided, to the extent of the incision, and the posterior part of the

rectus sheath and peritoneum are divided together, the opening being an inch in length. A portion of the cardiac end of the stomach is then brought up through the wound and held forward by an assistant until four sutures are inserted into the base of the cone by means of a curved intestinal needle, thus fixing the visceral peritoneum of the stomach to the edges of the parietal peritoneum.

A transverse incision of half an inch is then made through the skin, one inch above the upper end of the first

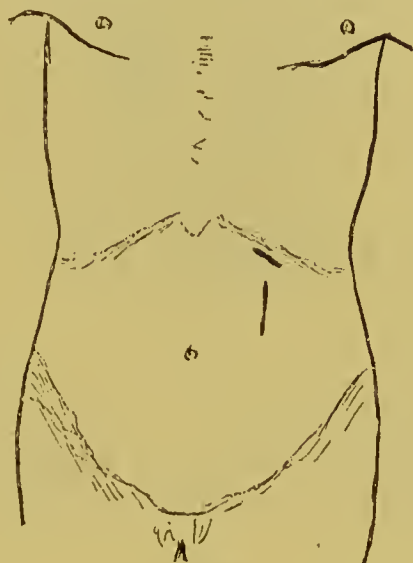


Fig. 1.

cut, and by means of a blunt instrument, such as the handle of a scalpel, a director, or forceps, the subcutaneous tissue is undermined so as to connect the two openings beneath a bridge of skin and subcutaneous tissue.

A closed pair of pressure forceps being introduced through the upper incision, as far as the projecting part of the stomach, grasps the most prominent part and draws it up to and beyond the surface of the second opening, where it is retained by means of two hare-lip pins, as in the diagram. It should just fill the opening and should require no sutures. The lower opening is now closed by two silkworm-gut sutures, or by a continuous subcutaneous stitch, and the edges are dried and covered with a little collodion and gauze. If needful, the stomach can be opened at once by a tenotomy

knife introduced between the pins, but, if possible, the opening should be deferred for twenty-four hours, when a barrier of lymph will have been thrown out.

After opening, a No. 8 soft catheter is inserted, to which

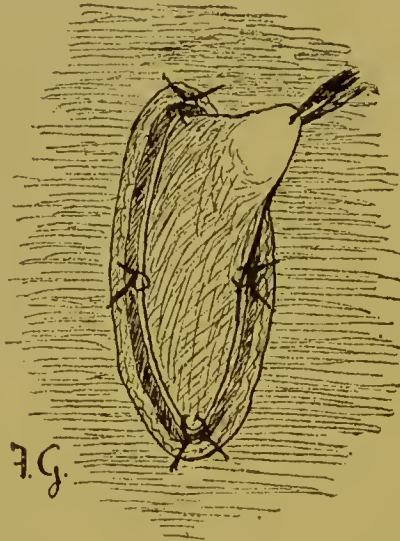


Fig. 2

a piece of tubing is fixed, and by means of a funne the patient can at once be fed with warm milk and egg, or whatever liquid may be thought desirable.

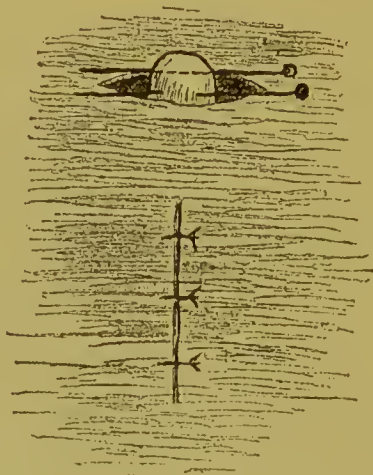


Fig. 3.

The catheter may be left in position for a few days, after which I find that it is easy to insert it whenever a meal is required.

The annexed diagrams will demonstrate the steps of the operation better than words, and it can be done almost more quickly than it can be described.

If the patient is much exhausted, an anæsthetic may be dispensed with and cocaine employed, as the only pain is caused by the skin incision.

I have performed this operation on many occasions and with most satisfactory results.

Little or no shock is experienced, as although the peritoneum is opened there is neither exposure of viscera nor handling of any organ except the portion of stomach to be fixed, and I have never known peritonitis to follow.

Where the operation is not deferred until "too late," death should not occur except from some accidental complication: for instance, I lost a patient at the end of the first week after operation from the unusual occurrence of an abscess caused by suppurating glands bursting into the trachea and flooding the bronchial tubes with pus. In that case I saw the patient in the morning, when he expressed himself as, and looked to be, doing well, and yet on returning in a few hours he was suffering from dyspnœa, was cyanosed and almost pulseless—in fact, he died within six hours of the rupture.

Even after gastrostomy for malignant stricture of the œsophagus I have seen as much as a stone and a half to be gained in weight.

In one case, in which I performed gastrostomy nearly three years ago for what I supposed to be a malignant stricture, the patient gained his health and weight completely, and sometime afterwards he regained the power of swallowing a little fluid, not sufficient, however, to support life, and he still makes use of his gastrostomy opening for feeding purposes. He has a mere dimple to represent the site of the stomach fistula into which he inserts, without the slightest difficulty, a No. 12 catheter "*à bouc*." There is no irritation around the opening, and even after so long a time there is no leakage of food or gastric fluid, so that he does not find it necessary to wear any apparatus or to have any dressing applied.

In advocating, therefore, the earlier and more frequent performance of the operation of gastrostomy in cases of dysphagia incapable of relief by ordinary means, I feel that I can do so as the result of ample experience of its beneficial results.